Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1912	A. BUILDING _____ B. WING _____	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILI	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the Licensure survey and complaint (#0029279), conducted February 12-14, 2012, at Imperial Gardens Health and Rehabilitation, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000	This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations.	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Bass

TITLE: Administrator

(X6) DATE: 3-15-12

STATE FORM 6899 J2KC11 If continuation sheet 1 of 1

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Bass — TITLE: Administrator — (X6) DATE: 3/1/2012

FORM CMS-2567(02-99) 6899 J2KC11 If continuation sheet 1 of 1